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ALL RECOVERED.

BY

W. F. McNUTT, M.D., L.R.C.P., Ed., &c.

Prof. Principles and Practice of Medicine,
University of California.

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FIVE CASES OF VAGINAL HYSTORECTOMY FOR MALIGNANT DISEASE OF THE UTERUS. ALL RECOVERED.

By W. F. McNUTT, M. D., M. R. C. S., Ed., etc.
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CASE NO. ONE.

Mrs. B., age fifty-seven, born New York, had one child, 1851, no cancer history, menstruated at seventeen, ceased at forty-one. At age fifty-three commenced having slight uterine hemorrhages; consulted several physicians in regard to it, had taken medicine and had astringent injections, etc., with the effect of partially controlling the bleeding. When she consulted me first at my office she had slight hemorrhage, mixed with a thick ropy albuminous looking discharge—found the uterus slightly enlarged, canal tortuous and irregular, and had difficulty in passing the sound, neck granular and bleeding easily, made applications with astringents, ordered lead and carbolic injections, advised rest. There being no improvement and considering the case cancerous, I called Dr. R. Beverly Cole in consultation; when we dilated the uterus, with Hager dilators, there was discharged at least a half an ounce of white-of-egg-like fluid mixed with blood, the whole neck of the uterus was nodular and presented an epithelial-like softened appearance. The woman was losing weight, strength and color, there was no mistaking the diagnosis, viz.: Epithelial cancer.

Mrs. B. having consented to an operation, I determined to make a vaginal hystorectomy, and on November 27th, 1888, removed the uterus. The external parts were shaved and thoroughly cleaned by soap and carbolized water, and the vagina was disinfected and the patient placed in the dorsal position. The uterus was brought down by a strong volsella and a small vertical incision was made through the anterior vaginal wall. An aneurism needle with a ligature was passed through the opening, and brought out through the wall three-fourths of an inch to the right; this section was tied and divided with scissors; this process was continued until the neck was enucleated, the connective cellular tissue was mostly broken up by the finger; the uterus was then easily brought further down, not turned

over, and the broad ligaments secured in mass by a carbolized silk ligature. I then put on long compression forceps on the ligaments between the ligatures and uterus, and divided the broad ligaments close to the uterus up to its upper margin, and over this undivided upper fold of the ligament, I placed a ligature and cut the uterus free. I then tied these last two ligatures together stretching the broad ligaments across the cavity and making a roof, as it were, to the vagina, the vagina was then packed with iodoform gauze, the forceps were taken off in forty-eight hours, and she was kept four weeks in bed, and now seventeen months after the operation is as well as she ever was. At no time after the operation was there any marked rise in temperature.

I was assisted in this operation by Drs. Winslow Anderson, J. C. Sundberg and Kate Howard.

Of the pathology of this case Prof. D. W. Montgomery says, Mrs. B. had an extensive neoplasm of the cervix uteri, both simple and malignant. The simple new growth was a papilloma. Below the papilloma was a epithelioma infiltrating very extensively the connective tissue.

CASE NO. TWO.

Mrs. P., aged forty-four, married at twenty, two children, youngest seventeen years old, had one miscarriage thirteen years ago, no cancer history. This case was under the care of Dr. W. H. Davies, who had attended her for several months for uterine hemorrhage, using internal remedies, injections and several times having to tampon the vagina with cotton saturated with solution of monsel's.

Dr. Davies told her his efforts were only affording her temporary relief and more radical measures would have to be tried. I was called in consultation and found the patient exsanguine to an alarming degree, an epithelioma of the cervix was unmistakable; the slightest touch caused profuse bleeding, necessitating the tampon after our examination. We advised removal of the uterus, and after a few days' delay she consented to the operation. July 25th, 1889, the operation was made, Dr. W. D. Garwood gave the patient ether, and, placing her in the lithotomy position, the epithelial fungous bleeding mass was curetted off and the bleeding in a measure controlled by hot water before the enucleation of the cervix was commenced. Drawing the uterus well down with a volsella, the enucleation was soon made, the adhesions separated, and the broad liga-

ments clamped with compression forceps (no ligatures used), uterus cut loose, and forceps left on fifty hours. The only difficulty encountered in this operation was the exhausted and exsanguine condition of the patient before commencing the operation. During the later part of the operation she was constantly plied with hypodermic injections of whiskey, which were necessary to keep up the heart's action.

In this operation, I was assisted by Drs. Davies, J. C. Sundberg, Winslow Anderson, Hodghead, W. H. Mays and Kate Howard.

This patient is in excellent health and spirits at the present time, nine months after the operation, with the exception that she has a small vesico-vaginal fistula, and which did not give any evidence of its presence until after the fourth week.

CASE NO. THREE—HYSTORECTOMY (FOR CANCER) AND OVARIOTOMY—DOUPLE OPERATION.

Mrs. F., age sixty-seven, a thin, wiry, but apparently well nourished old lady came to Dr. R. M. Elliott, of this city, from Washington Territory on June 24th, 1889, suffering from an offensive discharge from the uterus. She had borne a large family of healthy children, and had never had any severe illness up to the present time.

While riding on a buckboard about five months ago, the horses in leaping a ditch tipped her backwards, and she fell, striking on her sacrum. The injury caused her considerable pain at the time, but it gradually passed off leaving no noticeable trouble afterwards. A smooth, elastic, immovable, round tumor could be felt through the abdominal wall in the region of the left ovary. There was a purulent vaginitis, and an excoriation of the os uteri with a purulent bad smelling discharge from the os. There had been at no time either pain or hemorrhage. After cauterization by Dr. Elliott with nitrate of silver, the solid stick, the excoriation healed in part, the discharge from the os in a great measure ceased, and she returned to the country much improved, but with a slight discharge from the vagina which still persisted, and for which an injection of sulphate of zinc and acetate of lead, each twenty grains; tincture of opium, one dram; and water to eight ounces was prescribed.

After two weeks she wrote stating the offensive discharge had returned just as before. On coming back to the city again for treatment a much more serious state of affairs was found than at

first. The discharge was as abundant as before instituting treatment, and a fungous easily bleeding mass was seen projecting from the os uteri.

Dr. Elliott called me in consultation and an operation was advised, the patient was sent to the Children's Hospital and the date of operation set for August, 11th.

Because of the abdominal tumor, the exact nature of which could not be determined before the operation, it was determined to first open the abdomen, examine its contents, and then act pro re nata. After a careful toilet, the abdomen was opened in the median line, and an ovarian cyst about the size of a cocoanut was found united by extensive adhesions to all the surrounding viscera, especially to the intestines. The adhesions were carefully separated, principally by the finger nails. After much labor the tumor was set free from the intestines, it still being firmly adherent to the uterus. The cyst contents were then evacuated. The uterus was found much enlarged, being about the size it should be at the second month of gestation; it was soft and boggy to the touch; and adherent to the surrounding tissues, especially posteriorly, an abscess being found between the uterus and the rectum. I then decided to enucleate the neck of the uterus per vagina and remove the uterus through the abdominal opening. In enucleating the neck and going up between the rectum and the uterus the aforementioned abscess was opened and a large quan tity of foul smelling pus was evacuated. The os uteri was also opened up and a large quantity of pus followed away from the uterine cavity. The pus being got rid of per vaginum, and the neck being thoroughly enucleated, the operative procedures were subsequently carried on through the abdominal opening, removing the entire womb, the cyst in connection with it, and the left Fallopian tube.

Despite the age of the patient, the length of the operation (lasting fully three hours), and the amount of disturbance caused by the breaking up of the very extensive adhesions and the separation of such large masses of tissue, the patient's temperature never went above 101°, and the only bad symptom was some meteorism occurring on the third day and gradually subsiding again. Very little blood was lost during the operation, a point of great importance in elderly persons in whom the blood-making functions are not active.

Mrs. F. sat up on the 14th day and left the hospital on the 28th.

I wish to acknowledge the assistance of Drs. Winslow Anderson, Brown, Elliott, Mays, Montgomery and Wanzer.

Dr. D. W. Montgomery's report on the pathology of the parts removed appeared in the reports of San Francisco Medical Society where the specimens were shown. He says that it was an epithelioma of the cervix uteri, the infiltration involved pretty much the whole cervix.

CASE NO. FOUR.

Mrs. P., age thirty-two, married, had children—was under Dr. S. S. Stambaugh's care for several months for fever, pain and uterine hemorrhage. I examined her in consultation with Dr. Stambaugh August 27, 1889; the uterus was much enlarged and immovable, cervix nodulated and vascular with granulating bleeding surface, broad ligaments thickened. There was a bad smelling vaginal discharge. There was no doubt about the cancerous nature of the disease. Mrs. P. came from a very malarious locality, and had high fever every day, notwithstanding Dr. Stambaugh had treated her for malaria.

We informed Mrs. P. of the nature of her disease, and that nothing but an operation offered her any chance from a disease which must soon prove fatal. The enlargement and fixed condition of the uterus with the involvement of the broad ligaments made the prospect for an operation bad. She, however, wanted to avail herself of the chance an operation would afford, and on September 12, 1889, I operated with the assistance of Drs. Stambaugh, Winslow Anderson, Paugh and Stone. After the usual careful preparation as to washing, shaving and vaginal antiseptics, the uterus was seized with strong volsella, but on account of the fixed condition could be pulled down but little, the neck was soon enucleated with the instruments which you see here, and which I had made for the purpose.

The extensive adhesions were broken up with great difficulty, and the ligaments were so involved that it was necessary to remove them as you see.

The hemorrhage was controlled by compression forceps, which remained on about fifty-two hours, no ligatures used, the vagina filled, as all the other cases were, with iodoform gauze and the woman put to bed. She at no time had so much fever after the operation as she had before, she made a good recovery.

CASE NO. FIVE.

Mrs. W., age 38, born in France, first menstruated at the age of 15, never was regular, married at 23, one miscarriage five

years after, caused by lifting a heavy weight, followed by metritis and peritonitis, was confined to bed two months, never fully recovered; no cancer history.

Began to complain of uterine pain and hemorrhage about three months ago, and for which she had consulted physicians at various times, who had given her medicine and injections without relief. She consulted Dr. Frances R. Marx, who, considering the case cancerous, called me in consultation. On examination I found great tenderness, the whole uterus enlarged and fixed, cervix indurated and nodular with very vascular granulation, which bled freely from the slightest touch; there was a constant watery, bloody colored discharge, having a characteristic odor; the cancerous cachexia was well marked and the diagnosis of cancer was unmistakable.

Being informed of the nature of her case and the only remedy, removal of the uterus, she at once consented to an operation. She was sent to the Children's Hospital. December 3, 1889, I removed the uterus. On account of the large size and fixed condition of the uterus, accompanied with the fact that the woman had never borne children, made the operation a most difficult one. After enucleating the cervix and separating the adhesions to the bladder it was still impossible to pull the uterus down—the attempt to turn it over backward was equally unsuccessful. After a time, however, I succeeded in turning it over forward, having fixed one blade of the volsella into the fundus and made steady traction. The broad ligaments were then clamped with compression forceps (no ligatures used), and the operation finished by cutting the broad ligaments. The vagina was packed with iodoform gauze and the forceps removed after forty-eight hours. This large fibrous tumor which you see in the fundus of the uterus is what prevented the uterus from descending and made it so impossible to turn it over backwards.

The operation altogether was very difficult, and the hemorrhage from this softened, vascular, broken down cervical portion was excessive and uncontrolable during the operation. The woman, though exsanguine by the time the operation was finished, made a good recovery, and is at the present time enjoying very fair health.

I was assisted by Drs. D. W. Montgomery, C. B. Brown, F. R. Marx, Winslow Anderson, A. A. D'Ancona and Wanzer. The first operation was the only one in which I used the aneur-

ismal needle and ligature in enucleating the cervix, in all the other cases the enucleation was made by these instruments, which I show you here and which I had made for the purpose.

It is not my purpose to discuss the etiology of cancer of the uterus with a view of determining its relation to laceration of the cervix, pregnancy, etc., nor to enter into any detailed account of the pathology or symptomatology of uterine cancer. But my object in reporting these cases is to call the attention of the members of this Society to the fact that we have in hystorectomy a remedy even for cancer of the uterus, and to assist in establishing hystorectomy as a legitimate and recognized surgical operation, and to hasten the time when the surgeon will as promptly and confidently resort to removal of the uterus for cancer as he does to the removal of the breast.

Of these five cases all were married women, four had borne children, while the fifth case had had one miscarriage.

About the frequency of cancer of the body of the uterus as compared with that of the cervix there is great diversity of opinion, as is also the case in regard to the merits of the operative procedures for cancer of the cervix, viz.: Whether to remove the cervix only or make hystorectomy. A recent able writer on cancer of the uterus, viz: Dr. John Williams, Professor of Obstetrics, in Queen's College, London, strongly advocates amputation of the cervix when the cancer apparently involves only the cervix, saying: "That it is possible to extirpate cancer from the uterus by supra-vaginal amputation, and that, in so far as the prevention of recurrence in the uterus itself is concerned, total extirpation of the organ presents no advantages over partial amputation."

It is not so surprising that Dr. Williams takes this ground, as he believes he has fully demonstrated that the tendency of cancer of the cervix is to spread laterally rather than to follow up the uterine cavity and involve the body of the womb. A careful examination by Prof. Montgomery of these uteri which you see here does not go to confirm Dr. Williams' opinion, that in cancer of the cervix the tendency is only to extend laterally. Dr. Montgomery found the cancer cell extending up the mucous lining of the uterine canal. While Dr. Williams advocates and practices the supra-vaginal amputation, he certainly has failed to make it clear how we are to diagnose with any certainty in which cases there is no cancerous involvement extending above the cervix.

There may be cases when this supra-vaginal amputation would be all that is necessary; in many cases, however, the cancerous tissue would not all be removed, and there is no means of differentiating the cases.

In connection with these cases I will crave the indulgence of the Society to say a word about laparotomy. Now that laparotomy has become so common, no one thinks of making an elaborate and detailed account of this operation. In the past year I have, however, made three or four that are not devoid of interest to those who are interested in abdominal surgery. Two of the cases proved to be intraligamentous cysts, one very large, no pedicle, embedded between the layers of the broad ligament deep into the pelvis. Enucleation was first attempted, but the capsule was so vascular that the attempt to shell it out had to be abandoned. I finally tied its whole broad base in eight sections; including too much tissue in the last section next to the uterus, the ligature cut the tissues and the bleeding was profuse. After cutting away the sac close to the ligatures, I resorted to powdered monsel's to stop the hemorrhage, which it did, using about three teaspoonfuls. A drainage tube was used and the wound closed in the usual manner. There was considerable inflammation with temperature of 104 for three or four days, when the fever subsided and the patient made a good recovery, and was out in five weeks. In the second intraligamentous case the cyst was small, and there was no difficulty in enucleating it. The hemorrhage, however, was very profuse, and was again checked by putting monsel's freely into the bed of the cyst. A drainage tube was used. Some fever followed, and the woman made a good recovery.

These two cases make up my experience with monsel's in the abdominal cavity. Just how to manage these intraligamentous cysts seems to be a matter for each individual operator to determine after he has opened the abdomen and carefully examined the case at hand. The third interesting case was that of a solid ovarian tumor weighing between seven and eight pounds. The woman, though very weak, made a good recovery.

Prof. Montgomery, after a careful examination, determined it to be a fibroid. While solid ovarian tumors are not common, the fibroid variety is probably the least common of all. The most troublesome part of the operation for these solid tumors often is the management of the intestines, owing to the great length of the opening required to lift out the tumor.